



360 degree Nissen Fundoplication



270 degree Toupet Fundoplication

Although Nissen total fundoplication is the most commonly performed procedure, partial fundoplication, either anterior or posterior, is becoming more acceptable because of lower risk of long term complication. The 360 degrees Nissen

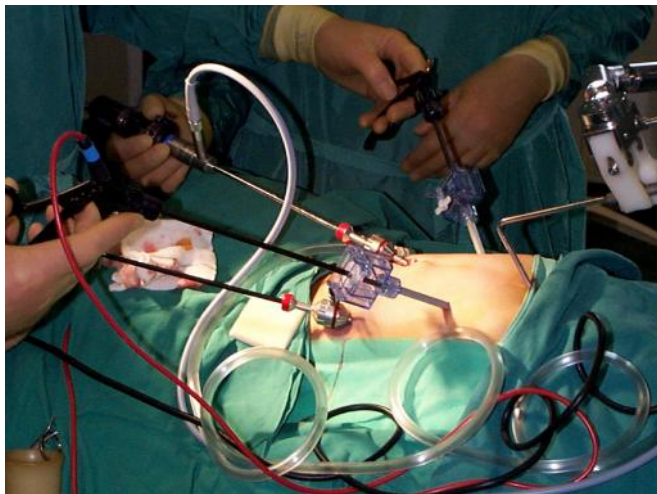
FUNDPLICATION

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Types of Fundoplication

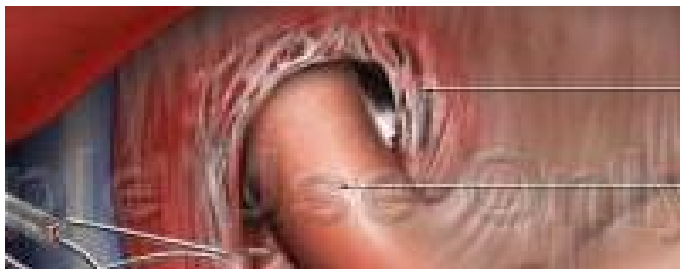
The 360 degrees Nissen fundoplication(NF)has been the standard operation for Gastro Esophageal Reflux, but is associated with substantial rates of, "gas bloat," gagging and dysphasia

A 5 mm port is positioned in the left mid clavicular line immediately below the costal margin. This port is mainly used for a forceps which will hold the tape encircling the oesophagus



Formal diagnostic laparoscopy performed,

To make the procedure easy first we try to show you some pictures, showing main steps of the procedure, and then we will see the steps in real images



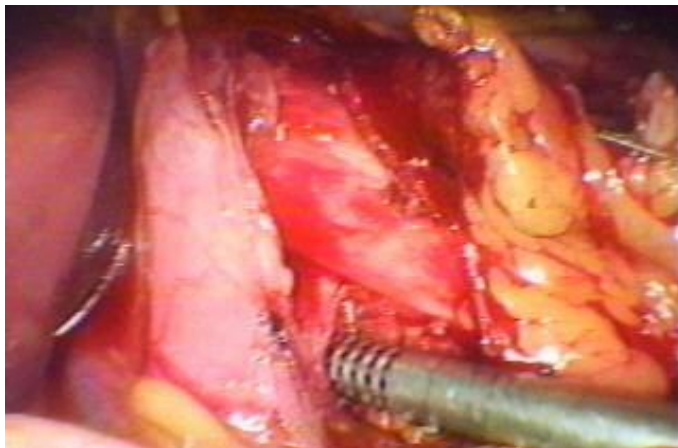
fundoplication (NF) has been the standard operation for Gastro Esophageal Reflux (GER), but is associated with substantial rates of recurrence, "gas bloat," gagging, and dysphagia. most surgeon believe that the Toupet fundoplication (TF), a 270 degrees posterior wrap originally described in conjunction with myotomy for achalasia, has fewer complications, and its long-term outcome in compared with Nissen Fundoplication is favorable both in children as well as adults.

PROCEDURE: Under general anesthesia, The patient is placed on the operating table with the legs in stirrups, the knees slightly bent and the hips flexed approximately 10°. The operating table is tilted head up by approximately 15 degree pneumoperitoneum created, ports inserted:

1. A 10mm camera port 5cm above the umbilicus.
2. A 5mm port in the right upper quadrant.
3. A port, with a variable 5-10 mm is in the left upper quadrant - a mirror image of the one on the patient's right.
4. Nathanson liver retractor is inserted through a 5 mm incision in the midline, extending from skin to the peritoneal cavity,

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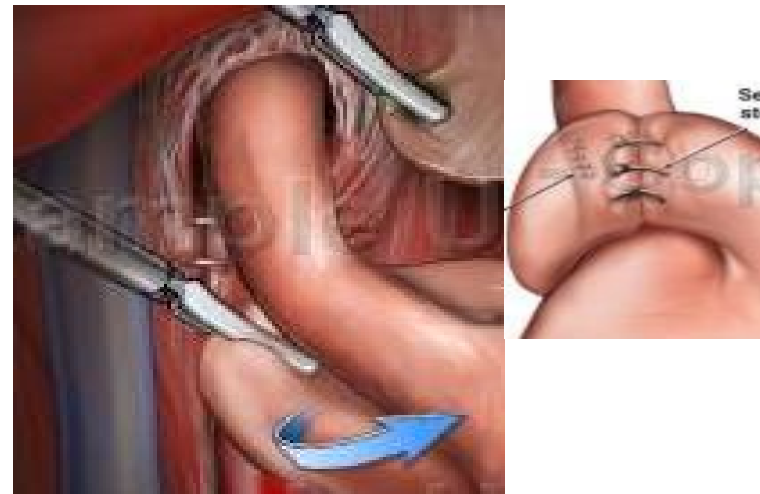
The operation starts by dividing the gastrohepatic and phrenoesophageal ligaments exposing the GE junction



The right crura have been dissected free, & the esophagus is being recognized.

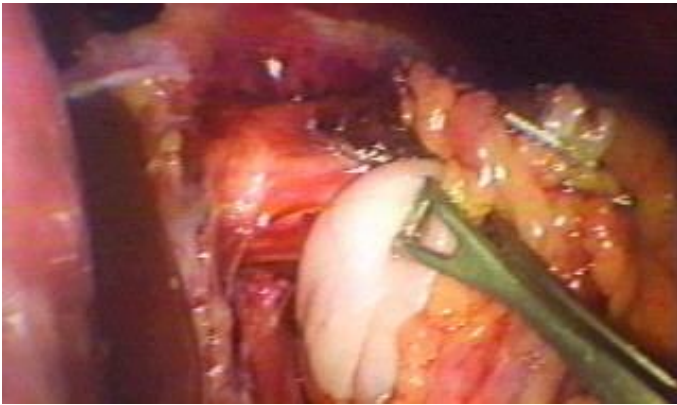


Suturing of the cruras

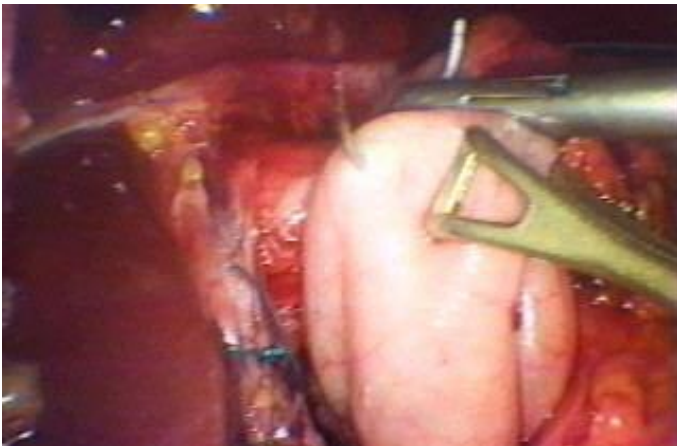


Wrapping of the esophagus with fundus and suturing of the fundal folds anterior to the esophagus





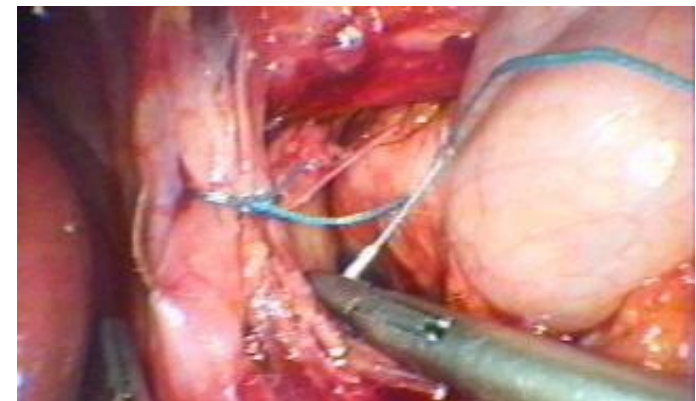
The stomach is grasped from behind the esophagus, to obtain a 360 degree "stomach-wrap" around the esophagus



Number "0" Ethibond stitch is placed between both gastric flaps.



An arterial vessel is being divided between clips to allow better mobilization of the stomach

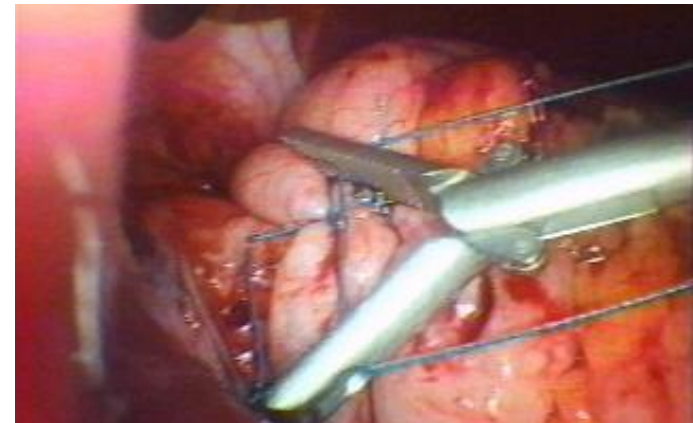


The right and left cruras are sutured with interrupted stitches to reduce the hiatus.

Number "0" Ethibond stitch is placed between both gastric flaps.

Postoperatively a chest X-ray is obtained in the recovery room to exclude a pneumothorax. Patients are begun on clear liquids on the day of surgery and soft diet the following day. Average length of stay is 2 days. Intraoperative complications may include injury to visceral organs, bleeding, pneumothorax and vagal injury. Postoperative complications include wrap slippage,

The Nissen wrap is anchored to the esophagus to avoid sliding



Stitches are tied off in an extra corporeal fashion using the "Knot Tier"

